Medicaid Enterprise
Department of Human Services

For Human Services use only:

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Employees' Manual, Title 8
Medicaid Appendix

March 13, 2009

INFANT AND TODDLER PROGRAM MANUAL TRANSMITTAL NO. 09-1

ISSUED BY: Bureau of Long-Term Care, Division of Medical Services

SUBJECT: ***Infant and Toddler Program Manual***, Table of Contents, page 1, new; Chapter III, P*rovider-Specific Policies*, Table of Contents (pages 1, 2, and 3), revised; pages 1, 2, 3, 12 through 16, and 22 through 52, revised; pages 53 and 54, new; and *Remittance Advice*, revised.

Summary

This release:

- Clarifies that notes that support each date of service are required.
- Clarifies that audiometrist services are not covered.
- Adds nutritional conditions that can be referred to a dietician.
- Adds the requirement that as of September 1, 2008, speech-language pathologists and audiologists must be licensed by the Iowa Department of Public Health to be covered by Medicaid.
- Expands the section on service coordination to:
  - Clarify requirements for service coordination in compliance with federal regulations.
  - Caution against billing services related to a direct care service as a service coordination service.
  - Eliminate one of the service coordination codes. All service coordination shall be billed in 15-minute units.
- Updates instructions for completing the claim form.
- Updates the *Remittance Advice* sample and explanation.
- Reorganizes services and procedure codes for them by alphabetical order.

Date Effective

February 1, 2009.

Material Superseded

Remove the following pages from the ***Infant and Toddler Program Manual*** and destroy them:

Page	Date
Contents (pp. 1-3)	April 1, 2007
1-3, 12-16, 22-48 *	April 1, 2007
Remittance Advice	6/21/97
49-52 *	April 1, 2007

* Due to renumbering pages to accommodate new material, those filing in printed manuals should refile the form samples as follows:

- Move form CMS-1500 to follow page 42 instead of page 38.
- Move form 470-3969 to follow page 50 instead of page 46.
- Move form 470-3816 to follow page 54 instead of page 52.

Additional Information

The updated provider manual containing the revised pages can be found at: www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquires to Iowa Medicaid Enterprise Provider Services Unit.

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. CONDITIONS OF PARTICIPATION

An infant and toddler program is eligible to participate in the Medicaid program when it is an agency in good standing under the Infant and Toddler with Disabilities Program under Subchapter III of the federal Individuals with Disabilities Education Act. In Iowa, this program is known as "Early ACCESS."

The provider must agree to remit the nonfederal share of the Medicaid payment to the Department of Human Services.

1. Personnel

Services shall be provided by personnel who meet the applicable professional licensure requirements. Local education agency and area education agency providers must meet the licensure requirement for the Department of Education rule 281 Iowa Administrative Code 41.8(256B,34CFR300), to the extent that their certification or license allows them to provide these services.

2. Treatment Plan Requirements

All services must be specific to a Medicaid-eligible child who:

- Is less than 36 months of age.
- Has a developmental delay or has an established condition that could result in a developmental delay later.
- Has an individual family service plan (IFSP) developed by the service coordinator pursuant to Department of Education rule 281 Iowa Administrative Code 41.5(256B,34CFR300), or is being assessed for eligibility for Early ACCESS services.

The IFSP must indicate measurable goals and outcomes and the type and frequency of services provided.

An updated IFSP that delineates the need for ongoing services is required at least every six months. The updated plan must:

- Include the child's current level of functioning.
- Set new goals and objectives when needed.
- Delineate the modified or continuing type and frequency of service.

3. Service Records

The provider shall maintain accurate and current documentation in the child's record of all services and activities provided. The record shall include, but is not limited to, the following:

- The first and last name of the child receiving the service. The child's name shall be on each page or separate electronic document.
- The child's Medicaid identification number and date of birth.
- The specific service provided.
- The complete date of service.
- The complete time of service, including beginning and ending time if the service is billed on a time–related basis. (Include AM or PM.)
- The first and last name and professional credentials, if any, of the person providing the service.
- The signature of the person providing the service, or the initials of the person if a signature log indicates the person's identity.
- A description of the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revisions of the diagnosis.
- Copies of the IFSP, including any changes or revisions to the IFSP.
- Progress or status notes on goals and objectives for which the services or activities provided.
- Documentation of service coordinator activities designed to locate, refer, obtain and coordinate services outside and inside the agency, as needed by the child.
- Record-keeping necessary for IFSP planning, service implementation, monitoring, and coordination. This includes preparation of:
  - Reports.
  - Service plan reviews.
  - Notes about activities in the service record.
  - Correspondence with the child and collateral contacts.

B. COVERAGE OF SERVICES

Payment will be made for medically necessary audiology, developmental services, health and nursing services, medical transportation services, nutrition services, occupational therapy services, physical therapy services, psychological evaluation and counseling, social work, speech-language services, vision services, and service coordination or case management services.

If assistive technology is required, use an enrolled Medicaid provider such as an optometrist, hearing aid dealer, or audiologist.

Obtain wheelchairs or prostheses through a Medicaid-enrolled durable medical equipment and supply dealer. To enroll in the Medicaid program as a medical equipment dealer, contact the IME Provider Services Unit at 1-800-338-7909, option 2, or 725-1004 (Des Moines local area).

1. Audiological Services

To be covered by Medicaid, audiological services must be provided by an audiologist licensed by the Iowa Department of Public Health.

The following services are covered when they are included in the child's IFSP or are linked to a service in the IFSP:

- Audiological screening
- Individual audiological assessment
- Audiological service to an individual
- Audiological service in a group
- Contracted audiological therapy services

a. Audiological Screening

Perform objective audiological screening in both ears using a pure-tone audiometer:

- At a minimum of 1000, 2000, and 4000 Hz
- Up to a maximum of 25 dB HL at any one frequency.

b. Individual Assessment

"Assessment" refers to the process of health data collection, observation, analysis, and interpretation for the purpose of formulating a nursing diagnosis. The initial assessment includes:

- Determining the need, nature, frequency, and duration of treatment.
- Determining the need for coordinating with other services.

Additional activities include:

- **Monitoring of IFSP implementation:** Activities designed to document whether the plan is meeting the child's needs by demonstrating maintenance or improvement in health status.
- **Evaluation:** Activities designed to evaluate the child's status in relation to established goals and the plan of care.

c. Nursing Service to an Individual

Individual nursing interventions involve executing the interventions in the plan of care, including ongoing assessment, planning, intervention, and evaluation.

The role of consultation is monitoring, supervising, teaching, and training professionals, paraprofessionals and parents in the home or community environment. Consultation includes:

- Providing general information about a child's condition.
- Teaching special skills necessary for proper care of child's medical needs.
- Making recommendations for enhancing a specific child's performance.
- Developing, maintaining, and demonstrating use and care of adaptive or assistive devices for a specific child.

d. Nursing Service to a Group

Services to a child or family provided in a group are identical in scope to the service activities listed for individuals, except that services are provided to more than one family at the same time. The services are designed to improve health status and effect change within the family to ensure the child's special health needs are met.

Early ACCESS services provided to a specific child must be provided in that child's "natural environment" unless the child's goals and outcomes cannot be met in the "the home or community setting when children of the same age without disabilities participate." A justification statement must be included on the IFSP if service is provided in another setting.

e. Contracted Nursing Service

Contracted services include nursing assessment and services to an individual that are rendered by a qualified practitioner who is a contractor, rather than an employee of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

f. Consultation

Consultation services are contracted services with a physician in the physician's office to obtain a specialized evaluation or reassessment.

5. Medical Transportation and Escort

To help ensure that members have access to medical care within the scope of the program, the Department reimburses for transportation and other costs, such as parking, to receive necessary medical care. The child must receive a Medicaid-covered service. Escort or attendant services are covered when the caretaker is not available.

Medical transportation must be included in the child's IFSP. Documentation for travel must be recorded in the child's record and must include:

- The date of service.
- The point of origin of travel (location).
- The location of service.
- Number of miles from the point of origin to the location of service.
- For a round trip, documentation for both ways.
- For escort services, "time in" and "time out," as services are billed in a time unit, and a short description of the child's status during the trip.

6. Nutrition Counseling

Infant and toddler providers are eligible for reimbursement of nutrition counseling services when a nutrition problem or a condition of such severity exists that nutrition counseling beyond that normally expected as part of the standard medical management is warranted. Services must be provided by licensed dietitians who are employed by or under contract with the provider.

Medical conditions that can be referred to a licensed dietitian include the following:

- **Inadequate or excessive growth**. Examples include failure to thrive, undesired weight loss, underweight, excessive increase in weight relative to linear growth, and major changes in weight-to-height percentile or BMI for the child's age.
- **Inadequate dietary intake**. Examples include formula intolerance, food allergy, limited variety of foods, limited food resources, and poor appetite.
- **Infant feeding problems**. Examples include poor suck or swallow, breast feeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, and limited information or skills of caregiver.
- **Chronic disease requiring nutritional intervention**. Examples include congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, diabetes, and gastrointestinal disease.
- **Medical conditions requiring nutritional intervention**. Examples include iron deficiency anemia, high serum lead level, familial hyperlipidemia, and hyperlipidemia.
- **Developmental disability**. Examples include increased risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, and tube feedings.
- **Psychosocial factors**. Examples include behaviors suggesting an eating disorder. Children with an eating disorder should also be referred to community resources and to their primary care provider for evaluation and treatment.

This is not an all-inclusive list. Other diagnoses may be appropriate and warrant referral to a licensed dietitian.

Nutrition services include:

- Information about the child's feeding skills.
- Assessment of the child's food habits and preferences.
- Developing a nutrition plan and reviewing progress.
- Information about the physical issues that affect growth and development.

The Supplemental Food Program for Women, Infants, and Children (WIC) is a primary payer for nutrition counseling. Medicaid will pay only if the service exceeds the service available through WIC. Patients must provide a statement that the need for nutrition counseling exceeds the services available through WIC.

7. Occupational Therapy

The following occupational therapy services are covered when they are in the child's IFSP or are linked to a service in the IFSP:

- Occupational therapy screening
- Individual occupational therapy assessment
- Occupational therapy service to an individual
- Contracted occupational therapy services

Occupational therapy services may be provided by:

- A licensed occupational therapist, or
- A licensed occupational therapy assistant as delegated and supervised by the licensed occupational therapist.

a. Occupational Therapy Screening

Screening is the process of surveying an individual through direct and indirect observation in order to identify previously undetected problems. Occupational therapists may be involved in screening a group of children, but more typically, the therapists consult and provide in-service for other staff who regularly screen groups of children.

Screening may include, but is not limited to, the use of any of the following methods:

- Review of written information (medical records)
- Review of spoken information (interview parents)
- Direct observation (checklists, a comparison with peers)
- Formal screening tools

Document referrals for evaluation or treatment services identified through the screening.

b. Individual Occupational Therapy Assessment

An assessment by an occupational therapist should consider information from each of the following areas as they affect the child's ability:

- Developmental motor level
- Neuromuscular and musculoskeletal components
- Functional motor skills:
  - Self-care
  - Mealtime skills
  - Manipulation skills

c. Occupational Therapy Service

(1) Direct Service Model

In a "direct service" model, the therapist works with a child individually. Typically, direct service is used when frequent program changes are needed and parents and other team members do not have the unique expertise to make these changes.

It is the therapist's professional judgment that determines when a licensed therapist or supervised licensed physical therapist assistant is the only person uniquely qualified to carry out the therapy program. The therapist, or an assistant under the supervision of the therapist, is the primary provider of service and is accountable for specific IFSP outcomes or measurable goals.

The emphasis of direct therapy is usually on the acquisition of basic motor or sensorimotor patterns or sequences needed for a new skill during a critical learning period. The child has not achieved a level of ability that would permit transfer of skills to other environments. Often only a short interval of direct service is needed before the child can participate in a less restrictive model of service.

Intervention sessions may include the use of therapeutic techniques or specialized equipment that require the therapist's expertise and cannot safely be used by others within the child's natural environment. In the direct service model, there is not an expectation that activities can be delegated to others and carried out between therapy sessions.

a. Psychological Screening

Psychological screening is the process of surveying a child through direct observation or testing in order to verify problems and determine if further assessment is needed. Document referrals for evaluation or treatment services identified through the screening.

b. Individual Psychological Assessment

"Assessment" refers to the process of collecting data for making treatment decisions. The initial assessment includes:

- Determining the need, nature, frequency, and duration of treatment.
- Deciding the needed coordination with others.
- Documenting these activities.

Additional assessment activities include:

- **Monitoring of treatment implementation:** Activities and procedures designed to document the child's improvement during treatment provision and to adjust the intervention plan as needed.
- **Treatment evaluation:** Activities and procedures designed to evaluate the summary effects of an intervention after a significant period.

c. Psychological Service to an Individual

Psychological services to an individual involve individual therapy. This service consists of supportive, interpretive, insight-oriented, and directive interventions.

The role of consultation is monitoring, supervising, teaching, and training professionals, paraprofessionals, and parents in the home or community environment. Consultation includes:

- Providing general information about a child's developmental delay or condition.
- Teaching special skills necessary to meet a child's medical needs.
- Making recommendations for enhancing a child's performance.

d. Contracted Psychological Services

Contracted psychological services include individual psychological assessment and direct psychological services to an individual or in a group that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the provider. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

10. Service Coordination

Payment will be made for medically necessary assistance and services provided by a service coordinator/case manager to a child receiving infant and toddler services and the child's family.

The coordinator serves as the single point of contact in assisting parents to obtain the services and assistance needed. The service coordinator assists the child and family to receive the rights, procedural safeguards, and services that are authorized to be provided under the infant and toddler program.

Service coordination assists children in gaining access to needed medical, social, educational, and other services. The service is intended to address the complexities of coordinated service delivery for children with medical, developmental, or psychosocial needs. The service coordinator should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need.

The service coordinator is responsible for:

- Explaining the infants and toddlers with disabilities program.
- Coordinating all services across agency lines.
- Identifying the family concerns related to the child's needs.
- Coordinating the performance of evaluations and assessments.
- Participating in Early Access data collection activities.

Service coordination does not include the direct delivery of an underlying medical, educational, or social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services. Examples of direct services include diagnostic tests or provision of medical transportation.

a. Qualifications

The service coordinator must be a practitioner who meets professional licensure requirements or meets the certification requirements in 281 Iowa Administrative Code 41.8(256B).

Medicaid approves the following licensed practitioners as service coordinators:

- Audiologist
- Dietitian
- Early childhood special educator
- Nurse
- Occupational therapist
- Occupational therapist assistant
- Orientation and mobility specialist
- Physical therapist
- Physical therapy assistant
- Physician
- Psychologist
- Social worker
- Speech language assistant
- Speech language pathologist
- Teacher for visual impairment

A paraprofessional can provide the service if supervised by a licensed practitioner.

Case management agencies certified through 441 IAC Chapter 90 may also provide service coordination services. Case managers must complete the service coordination competency–based training program through the Department of Education.

b. Conflict of Interest

If the agency that provides service coordination also provides direct services, the service coordination unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

c. Choice of Provider

In the future, families of children who are eligible to receive targeted case management services both through an HCBS waiver and under Early ACCESS will determine which program will provide case management service for both the HCBS program and Early ACCESS.

The family has the right to choose freely among those entities that are qualified and willing to provide case management services. The service coordinator should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need.

d. Comprehensive Assessment and Reassessment

A comprehensive assessment and periodic reassessment of the child shall be completed. The assessment shall identify all of the child's service needs, including the need for any medical, educational, social, or other services, such as housing or transportation. Assessment activities are defined to include the following:

- Taking the child's history;
- Identifying the needs of the child and the child's strengths and preferences;
- Considering the child's physical and social environment;
- Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
- Completing documentation of the information gathered and the assessment results;
- Identifying a course of action to respond to the assessed needs of the child;
- Referral and related activities to help the eligible child obtain needed services; and
- Reviewing the child's plan of care every six months to determine whether the child's needs or preferences have changed.

e. Plan of Care

The service coordinator shall develop and periodically revise a plan of care for the child. The plan of care shall:

- Be based on information collection through an assessment or reassessment
- Specify goals of providing services to the child, and
- Specify actions to address the child's medical, social, educational, and other service needs, which may include activities such as:
  - Ensuring the active participation of the child, and
  - Working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

f. Contact With the Child and Family

The service coordinator shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months when there is no face-to-face contact, dialogue between the service coordinator and the family by telephone or e-mail is required.

g. Activities to Help a Child Obtain Needed Services

The service coordinator shall help to link the child with needed services including activities that help link children with medical, social, or educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals in the plan of care. Referral activities include:

- Assisting the family in gaining access to the infant and toddler program services and other needed services identified in the child's plan of care.
- Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.
- Making referrals to providers for needed services.
- Scheduling appointments for the child.

- Facilitating the timely delivery of services.
- Arranging payment for medical transportation

Referral activities do not include provision of the direct services, program, or activities to which the child has been linked.

h. Monitoring and Follow-Up Activities

The service coordinator shall monitor the IFSP and perform follow-up activities as appropriate. Monitoring and follow-up activities may be with the child, family members, providers, or other entities.

The purpose of these activities is to help determine:

- Whether services are being furnished in accordance with the child's plan of care.
- Whether the services in the plan of care are adequate to meet the needs of the child.
- Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

i. Transitioning From a Medical Institution to the Community

When a child resides in a medical institution such as a hospital, the medical institution is responsible for case management. However, children transitioning to a community setting after a significant period of time in a hospital or other medical institution require service coordination beyond the scope of work of discharge planners.

If the child's stay in the institution has been less than 180 days, service coordination services may be provided during the last 14 days before the child's discharge. If the child has been in the institution 180 consecutive days or longer, the child may receive service coordination services during the last 60 days before the child's planned discharge.

The plan of care must include the amount, duration, and scope of the service coordination activities before and after discharge. Claims cannot be submitted to Medicaid until the child leaves the institution, is enrolled with the service coordination, and receiving medically necessary services in a community setting.

j. Keeping Records

The service coordinator shall prepare reports, update the plan of care, make notes about plan activities in the child's record, and prepare and respond to correspondence with the family and others.

k. Documentation of Service Coordination

For each child receiving service coordination, the case record must document:

- The name of the child,
- The dates and time of service coordination services,
- The agency chosen by the family to provide service coordination
- The name of the person providing the service coordination,
- The nature, content, and units of service coordination received,
- Whether the goals specified in the care plan have been achieved,
- Whether the family has declined services in the care plan,
- Timelines for providing services and reassessment, and
- The need for and occurrences of coordination with case managers of other programs.

Documentation that ongoing service coordination contact was provided shall consist of case notes that meet the following criteria:

- Date, time, and duration of contact.
- Who was contacted.
- The reason for a coordination contact.
- A brief summary of what transpired during the contact.
- An action, reaction, or decision by the coordinator.
- Signature of coordinator and license

The notes will serve as documentations that the service was provided. The service must relate to the IFSP goals.

11. Speech-Language Therapy

The following speech-language services are covered when they are in the child's IFSP or are linked to a service in the IFSP:

- Speech-language screening
- Individual speech-language assessment
- Speech-language service to an individual
- Contracted speech-language service

To be covered, speech-language services must be provided by a speech-language pathologist licensed by the Iowa Department of Public Health (IDPH).

a. Speech-Language Screening

Speech-language screening is the process of surveying a child through direct supervision by a speech-language pathologist in order to identify previously undetected speech and language problems such as:

- Articulation
- Receptive and expressive language
- Voice
- Fluency
- Oral motor functioning
- Oral structure

Document referral for evaluation or treatment service identified through the screening.

b. Individual Speech-Language Assessment

Individual speech-language assessment refers to the process of gathering and interpreting information through:

- The administering of tests or evaluative instruments
- Observation
- Record review
- Interviews with parents

Results of the assessment may identify delay or disorder in one or more of the following areas:

- Articulation
- Language
- Fluency
- Voice
- Oral motor, feeding, or both

Based on these assessments, the individual needs are identified, planned for, and documented, including amount of services.

c. Speech-Language Service to an Individual

Speech-language services to an individual are one-on-one speech-language services provided by a speech-language pathologist or communication aide.

d. Contracted Speech-Language Services

Contracted speech-language services are covered only when provided by a licensed or certified speech-language pathologist.

Contracted speech-language services include screening, assessment and therapy services which are rendered by a qualified practitioner who is a contractor, rather than an employee, of the provider. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

12. Social Work Services

Social work services include assessment, diagnosis and treatment services including, but not limited to:

- Administering and interpreting clinical assessment instruments.
- Completing a psychosocial history.
- Obtaining, integrating, and interpreting information about child behavior.
- Planning and managing a program of therapy or intervention services.
- Providing individual, group, or family counseling.
- Providing emergency or crisis intervention services.

Providing consultation services to assist other service providers or family members in understanding how they may interact with a child in a therapeutically beneficial manner.

Medicaid covers the following services when they are when they are in the child's IFSP or are linked to a service in the IFSP:

- Social work screening
- Social work assessment
- Individual services
- Group services
- Contracted services

For services to be covered, they must be provided by a licensed social worker.

a. Social Work Screening

Screening is the process of surveying a person through direct observation or group testing in order to verify problems and determine if further assessment is needed.

Document referrals for evaluation or treatment services identified through the screening.

b. Social Work Assessment

"Assessment" refers to the process of collecting data for the purpose of making treatment decisions. These decisions may require:

- Determining the need, nature, frequency, and duration of treatment.
- Deciding the needed coordination with others.
- Documenting these activities.

Categories of treatment decisions in addition to screening are:

- **Monitoring of IFSP implementation:** Activities and procedures designed to document the child's progress during treatment provision and to adjust the treatment plan as needed.
- **Treatment evaluation:** Activities designed to evaluate the effects of an intervention after a significant period.

c. Individual Services

Services to an individual involve individual therapy. This service may use any model of therapy and clinical practice.

The role of consultation is monitoring, supervising, teaching, and training professionals, paraprofessionals, and parents in the home or community environment. Consultation includes:

- Providing general information about a child's developmental delay or condition.
- Teaching special skills necessary to meet a child's needs.
- Making recommendations for enhancing a child's performance.

d. Group Services

Services to a group include the following therapeutic services:

- **Group therapy:** This service is designed to enhance socialization skills, peer interaction, and expression of feelings.
- **Family therapy:** This service consists of sessions with one or more family members, for the purposes of effecting changes within the family structure, communication, and clarification of roles.

Early ACCESS service provided to a specific child must be provided in that child's "natural environment" unless the child's goals and outcomes cannot be met in "the home or community setting when children of the same age without disabilities participate." A justification statement must be included on the IFSP if service is provided in another setting.

e. Contracted Service

Contracted services include clinical assessment and direct services to an individual or in a group that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

13. Vision Services

Vision services include:

- Identification of the range, nature, and degree of vision loss.
- Consultation with a child and parents concerning the child's vision loss and appropriate selection, fitting or adaptation of vision aides.
- Evaluation of the effectiveness of a vision aide.
- Orientation and mobility services.

Medicaid covers the following services when they are in the child's IFSP or are linked to a service in the IFSP:

- Vision screening
- Vision assessment
- Services to an individual or group
- Contracted vision services
- Orientation and mobility services

For services to be covered, they must be provided by personnel who are licensed or certified to provide vision services.

a. Vision Screening

Screening is the process of assessing vision through direct observation in order to identify problems and determine if further assessment is needed.

Documentation is required if the child is referred for evaluation or treatment services identified through the screening. Document referrals when they are made.

b. Vision Assessment

Assessment refers to the process of collecting data for the purpose of making treatment decisions. These decisions may require:

- Determining the need, nature, frequency, and duration of treatment.
- Determining the need for coordination with other providers.
- Documenting these activities.

c. Services to an Individual or Group

Individual intervention is designed to enhance vision or orientation and mobility skills of an individual.

Group services involve two or more persons and are designed to enhance vision or orientation and mobility skills of the group.

The role of consultation is monitoring, supervising, teaching, and training professionals, paraprofessionals, and parents in the home or community environment. Consultation includes:

- Providing general information about a child's condition.
- Teaching specific skills necessary to meet a child's needs.
- Developing, maintaining, and demonstrating use of adaptive or assistive devices for a specific child.
- Making recommendations to enhance a child's performance.

Early ACCESS service provided to a specific child must be provided in that child's "natural environment" unless the child's goals and outcomes cannot be met in "the home or community setting when children of the same age without disabilities participate." A justification statement must be included on the IFSP if service is provided in another setting.

d. Contracted Vision Services

Contracted service includes vision assessment and direct services for an individual or group that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain the same.

e. Orientation and Mobility Services

Orientation and mobility services are services provided to eligible blind or visually impaired children by qualified personnel to enable those children to attain systematic orientation to and safe movement within their environments in home and community.

The services include teaching the children as appropriate:

- Spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibrations) to establish, maintain, or regain orientation and line of travel (e.g., traveling in the direction of the caregiver's voice).
- Use of the long cane to supplement visual travel skills or as a tool for safely negotiating the environment for children with no available travel vision.
- Use of remaining vision and distance, low-vision aids and other concepts, techniques, and tools.

C. SERVICE EXCLUSIONS

The following services shall not be covered:

- Administrative functions that are purely IDEA functions, such as scheduling IFSP team meetings and providing the requisite prior written notice.

  Service coordination can cover services where IDEA and Medicaid overlap, but not for administrative activities that are required by IDEA but not needed to assist children in gaining access to needed services.

  The administrative activities required by IDEA includes activities such as writing an IFSP, providing required notices to parents, preparing for or conducting IFSP meetings, or scheduling or attending IFSP meetings.

  Activities that are allowable as Medicaid service coordination include taking the child's history, identifying service needs, and gathering information from other sources to form a comprehensive assessment.
- Services that are provided but are not documented in the child's IFSP or linked to a service in the IFSP, including screening or assessment.
- Services rendered that are not provided directly to the eligible child or for a family member on behalf of the eligible child.
- Canceled visits or appointments that are not kept.
- Sessions that are conducted for family support, education, recreational, or custodial purposes, including respite or child care.
- Consultation services that are not specific to an eligible child or are not consistent with the IFSP.

- Service coordination that is provided when another service that has Medicaid case management components (such as HCBS waiver) is also being provided.
- Two Medicaid services provided simultaneously.
- Child Find activities.
- Activities that constitute the direct delivery of underlying medical, educational, social or other services to which a child have been referred.
- Activities that are an integral component of other covered service.
- Service coordination to children in medical institutions that duplicates institutional discharge planning, unless the services are to transition a child to the community.

NOTE: CMS policy states, "payments for allowable Medicaid case management services must not duplicate payments that have been, or should have been, included as part of a **direct** medical service…Activities that are considered integral to, or an extension of, the specified covered service are included in the rate set for the direct service, therefore they should not be claimed as case management. For example, when an agency provides a medical service, the practitioner should not bill separately for the cost of a referral as a case management service. These activities are properly paid for as part of the medical service."

D. BASIS OF PAYMENT

Infant and toddler program providers are reimbursed based on a fee schedule. The amount billed should reflect the actual cost of providing the services. The fee schedule amount is the maximum payment allowed.

Billing information is student-specific. Bill all procedures in whole units of service. Unless otherwise specified, a unit equals 15 minutes. Round remainders of seven minutes or less down to the lower unit and remainders of more than seven minutes up to the next unit.

Consultation services are billed per consultation. Guidelines are given for the average amount of time spent per consultation.

NOTE: If the costs of any part of case management services are reimbursable under another program, such as foster care or child welfare, the cost must be allocated between those programs and Medicaid in accordance with OMB Circular No. A–87 or any related or successor guidance or regulations regarding allocation of costs.

E. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS). Claims submitted without a procedure code and an ICD-9-CM diagnosis code will be denied. Use the ICD-code related to the service need as the primary diagnosis. Do not use ICD-9 codes 317 through 319 as a primary code. Those codes are not payable by Medicaid.

In certain instances, two-digit modifiers are applicable. They should be placed after the five-position procedure code. Possible modifiers are shown below:

Modifier	Definition
AH	Clinical psychologist
AJ	Social worker
GN	Speech pathologist
GO	Occupational therapist
GP	Physical therapist
HQ	Group setting
TD	RN
TE	LPN
TL	Early intervention contracted services
U9	Other health associate
UA	Audiologist

Procedure codes applicable to infant toddler services are as follows:

Code	Modifier	Description
Consultation		
99241		Consultation services for a new or established patient, which requires three key components: • A problem-focused history, • A problem-focused examination, and • Straightforward medical decision making. Usually, the presenting problems are self-limited or minor. Practitioners typically spend 15 minutes face-to-face with the patient or family.
99242		Consultation services for a new or established patient, which requires three key components: • An extended problem-focused history, • An expanded problem-focused examination, and • Straightforward medical decision making. Usually, the presenting problems are of low severity. Practitioners typically spend 30 minutes face-to-face with the patient or family.

Code	Modifier	Description
99243		Consultation services for a new or established patient, which requires three key components: • A detailed history, • A detailed examination, and • Medical decision making of low complexity. Usually, the presenting problems are of moderate severity. Practitioners typically spend 40 minutes face-to-face with the patient or family.
99244		Office consultation for a new or established patient, which requires these three key components: • A comprehensive history, • A comprehensive examination, and • Medical decision making of moderate complexity. Usually, the presenting problems are of moderate to high severity. Practitioners typically spend 60 minutes face-to-face with the patient or family.
99245		Consultation services for a new or established patient, which requires three key components: • A comprehensive history, • A comprehensive examination, and • Medical decision making of high complexity. Usually, the presenting problems are of moderate to high severity. Practitioners typically spend 80 minutes face-to-face with the patient or family.
Development		
T1023		Screening to determine the appropriateness of consideration of a child for participation in a specified program, project, or treatment protocol; per encounter. Use appropriate modifier.
96110		Developmental assessment, limited: (e.g., Developmental Screening Test II, Early language Milestone Screen), with interpretation and report; per test
96111		Developmental assessment, extended: (includes assessment of motor, language, social, adaptive or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development) with interpretation and report; per hour
96152		Health and behavior intervention, individual; per 15 minutes
96152	TL	Health and behavior intervention, individual by contracted staff; per 15 minutes
96153		Health and behavior intervention, group; per 15 minutes
Family Training		
T1027		Family training and counseling for child development, per 15 minutes

Code	Modifier	Description
Hearing		
V5008		Hearing screening, per encounter
92506		Evaluation of speech, language, voice, communication, auditory processing, and aural rehabilitation status; per 15 minutes
92507	UA	Treatment of speech, language, voice, communication, or auditory processing disorder, individual; per 15 minutes
92507	TL	Treatment of speech, language, voice, communication, or auditory processing disorder, individual by contracted staff; per 15 minutes
92508		Treatment of speech, language, voice, communication, or auditory processing disorder, group; per 15 minutes
Nursing Service		
T1023	TD or TE	Screening to determine the appropriateness of consideration of a child for participation in a specified program, project or treatment protocol; per encounter (TD indicates RN; TE indicates LPN)
T1001		Nursing assessment and evaluation, per 15 minutes
T1002		RN services, per 15 minutes
T1003		LPN services, per 15 minutes
T1002	TL	RN services by contracted staff, per 15 minutes
T1003	TL	LPN services by contracted staff, per 15 minutes
T1002	HQ	RN services group, per 15 minutes
T1003	HQ	LPN services group, per 15 minutes
Nutrition		
97802		Nutrition therapy assessment and intervention, per 15 minutes
97803		Nutrition therapy reassessment and intervention, per 15 minutes
Occupational Therapy		
T1023	GO	Screening to determine the appropriateness of consideration of a child for participation in a specified program, project, or treatment protocol; per encounter
97003		Occupational therapy evaluation, per 15 minutes
97530	GO	Therapeutic activities, direct patient contact by the provider; per 15 minutes
97530	TL	Therapeutic activities, direct patient contact by the provider by contracted staff; per 15 minutes
97535	GO	Self-care or home management training, per 15 minutes
97535	TL	Self-care or home management training by contracted staff, per 15 minutes
97537	GO	Community or work reintegration, per 15 minutes
97537	TL	Community or work reintegration by contracted staff, per 15 minutes

Code	Modifier	Description
Orientation and Mobility		
97139		Unlisted therapeutic procedure, per 15 minutes
Transportation		
A0110		Non-emergency transportation, bus round trip
A0100		Non-emergency transportation, taxi round trip
A0130		Non-emergency transportation, wheelchair van round trip
A0090		Non-emergency transportation, per mile, volunteer, interested individual, neighbor
A0120		Non-emergency transportation, mini-bus, other nonprofit transportation systems; round trip
T2001		Non-emergency transportation; patient attendant or escort. Use modifier U9 for non-nurse service.
Physical Therapy		
T1023	GP	Screening to determine the appropriateness of consideration of a child for participation in a specified program, project or treatment protocol; per encounter
97001		Physical therapy evaluation, per 15 minutes
97530		Therapeutic activities, direct patient contact by the provider; per 15 minutes
97116		Gait training, per 15 minutes
97537		Community or work reintegration, per 15 minutes
97535		Self-care or home management training, per 15 minutes
97530	TL	Therapeutic activities, direct patient contact by the provider or by contracted staff
97116	TL	Gait training by contracted staff, per 15 minutes
97537	TL	Community or work reintegration by contracted staff, per 15 minutes
97535	TL	Self-care or home management by contracted staff, per 15 minutes
Psychologist		
T1023	AH	Screening to determine the appropriateness of consideration of a child for participation in a specified program, project, or treatment protocol; per encounter
96101		Psychological testing with interpretation and report, per 60 minutes
90804	AH	Individual psychotherapy, per 30 minutes
90804	TL	Individual psychotherapy by contracted staff, per 30 minutes

Code	Modifier	Description
Service Coordination		
T1017		Targeted case management, per 15 minutes
Social Work		
T1023	AJ	Screening to determine the appropriateness of consideration of a child for participation in a specified program, project or treatment protocol; per encounter
H0031		Mental health assessment by non-physician, per 15 minutes
H0046	TL	Mental health services, not otherwise specified by contracted staff; per 15 minutes
90804	AJ	Individual psychotherapy, per 30 minutes
90853	AJ	Group psychotherapy, per 30 minutes
Speech Language		
V5362		Speech screening, per encounter
V5363		Language screening, per encounter
92506	GN	Evaluation of speech, language, voice, communication, auditory process, or aural rehabilitation status; per 15 minutes
92507	GN	Treatment of speech, language, voice, communication, auditory processing disorder, individual; per 15 minutes
92507	TL	Treatment of speech, language, voice, communication, and/or auditory processing disorder, individual by contracted staff; per 15 minutes
Vision		
92012		Ophthalmological services, examination and evaluation; per 15 minutes
92014		Comprehensive services, established patient; per 15 minutes
92014	TL	Comprehensive services, established patient by contracted staff; per 15 minutes
92499		Unlisted service (use for group vision service), per 15 minutes
99172		Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determinations for contrast sensitivity, and vision under glare); per 15 minutes
99173		Screening test of visual acuity, quantitative, bilateral; per 15 minutes

F. INSTRUCTIONS AND CLAIM FORM

1. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the CMS-1500 claim form. To view a sample of this form on line, click here.

The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual member's situation.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**REQUIRED** Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED** Enter the Medicaid member's Medicaid number, found on the *Medical Assistance Eligibility Card*. The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	**REQUIRED** Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	**OPTIONAL** Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
4.	INSURED'S NAME	**OPTIONAL** For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	**OPTIONAL** Enter the address and phone number of the member, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	**REQUIRED, IF KNOWN** Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME, ETC.	**SITUATIONAL** Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	**REQUIRED, IF KNOWN** Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL** No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**REQUIRED** If the Medicaid member has other insurance, check "yes" and enter payment amount in field 29. If "yes," then boxes 9a-9d must be completed. If there is no other insurance, check "no." If you have received a denial of payment from another insurance, check **both** "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record. Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902. **Note:** Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY	**SITUATIONAL** Enter the date of the onset of treatment as month, day, and year. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	**SITUATIONAL** Chiropractors must enter the current x-ray date as month, day, and year. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	**OPTIONAL** No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
FIELD NUMBER	**FIELD NAME / DESCRIPTION**	**INSTRUCTIONS**
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	**SITUATIONAL** Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the healthcare provider that directed the patient to your office.
17a.		**LEAVE BLANK**. The claim will be returned if any information is entered in this field.
17b.	NPI	**SITUATIONAL** ♦ If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit NPI of the referring provider. ♦ If this claim is for consultation, independent laboratory services, or medical equipment, enter the NPI of the referring or prescribing provider. ♦ If the patient is on lock-in and the lock-in provider authorized the service, enter the NPI of the authorizing provider.
18.	HOSPITALIZATION DATES RELATED TO...	**OPTIONAL** No entry required.
19.	RESERVED FOR LOCAL USE	**OPTIONAL** No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL** No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED** Indicate the applicable ICD-9-CM diagnosis codes in order of importance to a maximum of four diagnoses (1-primary, 2-secondary, 3-tertiary, and 4-quaternary). If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, and V23

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	**SITUATIONAL** If there is a prior authorization, enter the prior authorization number. Obtain the prior authorization number from the prior authorization form.
24. A	DATE(S) OF SERVICE/NDC TOP SHADED PORTION	**SITUATIONAL** Required for provider-administered drugs. Enter qualifier "N4" followed by the national drug code for the drug referenced in 24d (HCPCs). Do not use spaces or symbols in this information.
	LOWER PORTION	**REQUIRED** Enter the month, day, and year under both the "From" and "To" categories for each procedure, service or supply. If the "From-To" dates span more than one calendar month, enter each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.
24. B	PLACE OF SERVICE	**REQUIRED** Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 81 Independent laboratory 99 Other unlisted facility
24. C	EMG	**OPTIONAL** No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED** Enter the codes for each of the dates of service. Do **not** enter the description. **Do not** list services for which no fees were charged. Enter the procedures, services or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show HCPCS code modifiers with the HCPCS code.
24. E	DIAGNOSIS POINTER	**REQUIRED** Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. **Do not** write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED** Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	**REQUIRED** Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the **total minutes** of general anesthesia.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. H	EPSDT/FAMILY PLANNING	**SITUATIONAL** Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	**LEAVE BLANK**. The claim will be returned if any information is entered in this field.
24. J	TOP SHADED PORTION: RENDERING PROVIDER ID # LOWER PORTION: NPI	**LEAVE BLANK.** The claim will be returned if any information is entered in this field. **REQUIRED** Enter the NPI of the provider rendering the service when the NPI given in field 33a does not identify the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL** No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**FOR PROVIDER USE** Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.
27.	ACCEPT ASSIGNMENT	**OPTIONAL** No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED** Enter the total of the line item charges. If more than one claim form is used to bill services performed, total each claim form separately. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**SITUATIONAL** Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	**REQUIRED** Enter the amount of total charges less the amount entered in field 29.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED** Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	**REQUIRED** Enter the name and address associated with the rendering provider.
32a.	NPI	**OPTIONAL** Enter the NPI of the facility where services were rendered.
32b.		**LEAVE BLANK**. The claim will be returned if any information is entered in this field.
33.	BILLING PROVIDER INFO AND PHONE #	**REQUIRED**. Enter the complete name and address of the billing provider. The address **must** contain the ZIP code association with the billing provider's NPI. NOTE: The ZIP code must match the ZIP code confirmed during NPI verification. To view the confirmed ZIP code, access imeservices.org.
33a.	NPI	**REQUIRED**. Enter the ten-digit NPI of the billing provider. NOTE: The NPI must match the NPI confirmed during NPI verification or during enrollment. To view the confirmed NPI, access imeservices.org.
33b.		**REQUIRED**. Enter qualifier "ZZ" followed by the taxonomy code of the billing provider. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification or during enrollment. To view the confirmed taxonomy code, access imeservices.org.

2. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- **Staple** the additional information to form 470-3969, *Claim Attachment Control*. (To view a sample of this form on line, click here.)
- Complete the "attachment control number" with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- **Do not** attach a paper claim.
- Mail the *Claim Attachment Control* with attachments to:

  IME Claims
  P.O. Box 150001
  Des Moines, IA 50315

Once IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

G. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

- **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- **Denied** represents all processed claims for which no reimbursement is made.

IAMC8000-R001 (CP-O-12)
AS OF 10/22/07

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 10/19/07

R E M I T T A N C E A D V I C E

TO: (1) R.A. NO.: 3(2)6 WARR NO.: 9(3)9 DATE PAID: 10/22/07 (4) PROV. NUMBER: (5) PAGE: (6) 1

**** PATIENT NAME **** LAST	FIRST MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* * * CLAIM TYPE: HCFA 1500 (7)								* * * CLAIM STATUS: PAID (8)					
ORIGINAL CLAIMS: (9)			(11)			(12)	(13)	(14)	(15)	(16)			(17)
		(10)	3-07290-00-015-0941-00		(21)	172.00	0.00	85.07	1.00				000 000
		(18) 01	(19) 10/04/07	99242 (20)	1	172.00	(22)	85.07 (24)	1.00 (25)	(26)		F	000 000
							(23)						
			3-07292-00-009-0053-00			69.00	0.00	32.36	0.00	(27)			000 000
		01	07/06/07	99212	1	69.00		32.36	0.00			F	000 000
			3-07288-00-010-0484-00			298.00	0.00	145.03	0.00				000 000
		01	07/11/07	99212 25	1	69.00		32.36	0.00			F	000 000
		02	07/11/07	29405	1	197.00		112.67	0.00			F	000 000
		03	07/11/07	A4590	1	32.00		0.00	0.00			K	177 000
			0-07281-22-009-0270-00			128.00	0.00	71.46	0.00				000 000
		01	06/14/07	20550	1	122.00		68.06	0.00			F	000 000
		02	06/14/07	J3301	2	6.00		3.40	0.00			F	000 000
4 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..						667.00	0.00	333.92	1.00				

TO: R.A. NO.: 3438496 WARR NO.: 9999999 DATE PAID: 10/22/07 PROV. NUMBER: PAGE: 2

**** PATIENT NAME **** LAST	FIRST	MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* * * CLAIM TYPE: HCFA 1500									* * * CLAIM STATUS: DENIED					
ORIGINAL CLAIMS:														
				3-07289-00-011-0880-00			69.00	0.00	0.00	0.00			499	000
			01	07/12/07	99212	1	69.00		0.00	0.00			K 000	000
1 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..							69.00	0.00	0.00	0.00				

TO: R.A. NO.: 3438496 WARR NO.: 9999999 DATE PAID: 10/22/07 PROV. NUMBER: PAGE: 3

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REMITTANCE T O T A L S					
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	4	---------	667.00	333.92
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	1	---------	69.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	---------	0.00	0.00
AMOUNT OF CHECK:					333.92

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE: COUNT:

29

177 THE PROCEDURE/SERVICE BILLED HAS BEEN DETERMINED TO BE NONCOVERED FOR THE DATE OF SERVICE SHOWN ON THE CLAIM. 1

499 INVALID OR MISSING MEDIPASS REFERRAL FOR RECIPIENT. 1

- **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click here.

A detailed field-by-field description of each informational line follows. Each *Remittance Advice* document contains important information about claims and expected reimbursement.

NO.	FIELD NAME	DESCRIPTION
1.	To:	Billing provider's name as specified on the Medicaid *Provider Enrollment Application*.
2.	R.A. No.:	Remittance Advice number.
3.	Warr No.:	The sequence number on the check issued to pay this claim.
4.	Date Paid:	Date claim paid.
5.	Prov. Number:	Billing provider's national provider identifier (NPI) number.
6.	Page:	*Remittance Advice* page number.
7.	Claim Type:	Type of claim used to bill Medicaid.
8.	Claim Status:	Status of following claims: • **Paid**. Claims for which reimbursement is being made. • **Denied**. Claims for which no reimbursement is being made. • **Suspended**. Claims in process. These claims have not yet been paid or denied.
9.	Patient Name	Member's last and first name.
10.	Recip ID	Member's Medicaid (Title XIX) number.
11.	Trans-Control-Number	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
12.	Billed Amt.	Total charges submitted by provider.
13.	Other Sources	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
14.	Paid by Mcaid	Total amount of Medicaid reimbursement as allowed for this claim.
15.	Copay Amt.	Total amount of member copayment deducted from this claim.

NO.	FIELD NAME	DESCRIPTION
16.	Med Recd Num	Medical record number as assigned by provider; 10 characters are printable.
17.	EOB	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for explanation of the EOB code.
18.	Line	Line item number.
19.	SVC-Date	The first date of service for the billed procedure.
20.	Proc/Mods	The procedure code for the rendered service.
21.	Units	The number of units of rendered service.
22.	Billed Amt.	Charge submitted by provider for line item.
23.	Other Sources	Amount applied to this line item from other resources, i.e., other insurance, spenddown.
24.	Paid by Mcaid	Amount of Medicaid reimbursement as allowed for this line item.
25.	Copay Amt.	Amount of member copayment deducted for this line item.
26.	Perf. Prov.	Treating provider's Medicaid (Title XIX) number.
27.	S	Allowed charge source code: **B** Billed charge **F** Fee schedule **M** Manually priced **N** Provider charge rate **P** Group therapy **Q** EPSDT total screen over 17 years **R** EPSDT total under 18 years **S** EPSDT partial over 17 years **T** EPSDT partial under 18 years **U** Gynecology fee **V** Obstetrics fee **W** Child fee

NO.	FIELD NAME	DESCRIPTION
28.	Remittance totals	(Found at the end of the *Remittance Advice*): • Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of paid adjusted claims, amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of denied original claims and the amount billed by the provider. • Number of denied adjusted claims and the amount billed by the provider. • Number of pended claims (in process) and the amount billed by the provider. • Amount of the check (warrant) written to pay these claims.
29.	Description of EOB code	Lists the individual explanation of benefits codes used, followed by the meaning of the code and advice.

H. MEDICAID BILLING REMITTANCE

Form 470-3816, *Medicaid Billing Remittance*, is used to notify the provider of the amount of the non-federal share paid to the provider in the previous month. It must accompany the payment for proper crediting. Please send the payment within 30 days of the date on the form. To view a sample of this form on line, click here.

Statement of Nonfederal Share is completed by the IME.

Completed by the provider agency:

- ♦ List the month and year that the agency was paid.
- ♦ Enter an authorized signature and date.
- ♦ Enter the name of agency.

There will be detailed information provided with this form for your information.